NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1. Quality standard title

Flu vaccination: increasing uptake

Date of quality standards advisory committee post-consultation meeting:   
03 October 2019

1. Introduction

The draft quality standard for flu vaccination: increasing uptake was made available on the NICE website for a 4-week public consultation period between 05 August and 03 September 2019. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 22 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* The importance of including carers explicitly in the eligible groups was highlighted, and suggestions were made for identifying and encouraging carers to receive flu vaccination whilst accompanying the person they care for to their vaccination appointment.
* It was suggested that more emphasis be given to actively targeting underserved groups, through better methods of communication and identifying settings for opportunistic vaccination.
* The role of community pharmacies in reaching underserved groups was highlighted.

### Consultation comments on data collection

* It was confirmed that systems for data collection are in place locally in Sheffield.
* It was confirmed that national systems for data collection relating to statements 1 and 4 are in place, however this does not include providers outside of the NHS.
* To make changes in the way the flu vaccine is provided data sharing agreements and quality standards would need to be met.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

### People in eligible groups are contacted about flu vaccination using a range of different methods.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* The effectiveness of digital engagement methods (social media, texting and emails) for younger age groups was highlighted.
* It was suggested that the way social media might be used be better defined or may be alongside other methods rather than a method of invitation alone.
* There was suggestion of using stronger wording than ‘contacted’ such as ‘invited’ and ‘encouraged to receive’.
* There was a suggestion that more emphasis could be put on the ‘recall’ element of this statement.
* There was a suggestion that written communications include an offer of face to face discussion or phone calls to answer questions.
* It was highlighted that capacity within GP IT systems for measuring this statement would need to be confirmed before implementation. There was suggestion that collection of this data could be incorporated in to existing local processes.
* It was highlighted that invites from community pharmacies are not necessarily recorded and collated, and that processes would need to be put in place to ensure that they are.
* Stakeholders highlighted that it is more important to use the correct method of invitation for an individual or group than to send invites in multiple forms that are unsuitable in order to meet the outcome measure. It was suggested that wording ‘appropriate to their individual needs’ is added to the statement.
* It was suggested that measures reference the invitations sent rather than invitations received as that may be difficult to verify.
* It was suggested that opportunistic invites be included to target people using secondary care services.
  1. Draft statement 2

### People in eligible groups receive invitations for flu vaccination that include information about their situation or clinical risk.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* It was suggested that the information be as tailored as possible to an individual, and a question was raised about how information would be given to people with more than one clinical risk.
* It was suggested that production of information could be done nationally where appropriate and that this would be more cost effective.
* There was concern raised about increased workload in primary care to produce the tailored information.
* There was concern raised about duplication of activity, and that it may not be recorded anywhere if a community pharmacy sends a tailored invitation.
* It was suggested that information supplied in invitations should also address concerns about the vaccine being dangerous for specific groups.
  1. Draft statement 3

### People in eligible groups who have the flu vaccine in a setting other than their GP surgery have their vaccination status shared with their GP.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* It was suggested that data collected includes a person’s clinical risk in order to better target specific eligible groups in the future.
* It was highlighted that new data sharing standards from NHS Digital that are currently being rolled out will help with the implementation of this quality statement.
* Concerns were raised about technological and resource barriers for the social care sector to implement this statement.
* It was suggested that a national standard be put in place with GP’s and other providers’ IT to ensure quality and consistency of data. Immform was suggested as the agreed national monitoring system.
* It was raised that patient consent is necessary to share information between health care providers and that this may need to be reflected in the statement wording.
* It was suggested that the statement be amended to include an obligation for GPs to record the vaccination status of a patient once it is shared with them.
  1. Draft statement 4

### Health and social care staff who have direct contact with people using services receive flu vaccination from their employer.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* It was suggested that this statement be extended to include all staff working in health in social care.
* It was highlighted that an electronic data collection system would need to be established for workers in the social care sector to capture information from smaller providers and that implementation might be difficult in general for smaller, local social care providers.
* It was suggested that hospice workers are specifically included in the quality statement as a type of social care worker.
* It was suggested that an agreed definition would need to be put in place for both social care workers and health care workers as there are currently differences between NHS Trusts and who they count as eligible.
* It was highlighted that some health and social care staff receive their flu vaccination from a pharmacy or GP and not directly from their employer so the statement could be amended to add ‘or nominated deputy’, and that data collection would need to take this in to account.
* It was suggested that local authorities should be listed under commissioners as they may commission outside providers for residential homes and similar services.
* It was suggested that collecting information about why staff decline the flu vaccine would be useful to inform future flu vaccination programmes.
* It was suggested that adding emphasis on local arrangements for ease of access for staff that work remotely/at night etc. would strengthen the statement.
* It was suggested that there should be sustained Government funding for social care flu vaccinations to help implement this quality statement.

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* It was suggested that GP practices could improve uptake by offering the vaccine to patients opportunistically.

© NICE 2019. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).

# Appendix 1: Quality standard consultation comments table – registered stakeholders

| **ID** | **Stakeholder** | **Statement number** | **Comments[[1]](#footnote-1)** |
| --- | --- | --- | --- |
|  | Association of Respiratory Nurse Specialists | 1 | We agree this is useful but are unsure if the systems and processes are in place to measure many of these accurately. Putting systems in place, maintaining and updating may take a significant amount of resources – would these resources be better placed in actually trying to vaccinate the doubters, vulnerable and difficult to reach in our communities?  We have concerns around the vulnerable such as the homeless; do we know how many homeless there are on our streets so how can we measure? How many of an unknown number who are then eligible and at risk get vaccinated? We think there needs to be a balance between measuring outcomes and effort into getting threat risk people vaccinated rather than concentrating on the vaccination process especially for vulnerable groups. |
|  | Asthma UK | 1 | We agree with the rationale that the best chance of improving uptake for people in at-risk groups (including people with asthma) is to use a variety of methods to contact them. We especially encourage the use of digital engagement methods, such as via social media promotion, texting and email, to encourage uptake amongst the widest population. Our research (https://www.asthma.org.uk/support-us/campaigns/publications/survey/) shows that those aged 18-29 receive the lowest levels of basic asthma care (33%, compared to 40% for all ages), so innovating in communication methods to reach this group is encouraged. Our research has shown that this age group is highly digitally literate, and are used to using technology in their healthcare (https://www.asthma.org.uk/307a2d3f/globalassets/get-involved/external-affairs-campaigns/publications/annual-asthma-care-survey/annual-asthma-survey-2017/asthmauk-annual-survey-2017.pdf). As well as collecting data on the number of people reached by methods such as social media and phone invitations, collecting data on what method encouraged attendance (as they may have heard about for flu vaccination may be helpful too, to plan for better targeting.  As well as reaching out through the methods discussed above, there are other methods that could help improve uptake. We have heard anecdotal evidence of GP practices improving vaccine uptake rates by offering the flu vaccination opportunistically, to at risk patients when they are attending for an unrelated reason. It can be hard to reach people with asthma, who may only attend their GP for their asthma once a year, for their annual asthma review. This opportunistic approach could be rolled out to other settings that people with asthma may contact, such as pharmacies, to further increase coverage and address those who may not attend a GP appointment - a recognised problem for the NHS (https://www.england.nhs.uk/2019/01/missed-gp-appointments-costing-nhs-millions). This approach may make the supply of vaccines harder to plan for, but indicates the sort of creative approach needed to ensure the most extensive coverage. |
|  | British Lung Foundation | 1 | We welcome the use of a multi-component approach to inviting people in eligible groups to receive their flu vaccination. The 2018 NICE guideline on increasing flu vaccination highlights that an approach which takes different measures to increase uptake is likely to have a greater impact than single interventions. It is also right that the draft quality standard recognises that ‘consideration to the target group’ is given when deciding what format the invitation should take and that this should be sent in a way that suits the patient (see quality measure b). However, it is unclear how service providers and health care practitioners will determine which method is suitable for each patient; further guidance on this would be welcome to ensure consistency. For example, within the chronic respiratory group, a different approach may be taken for people with asthma who are likely to younger and digitally literate, compared to people with COPD, who may be more digitally excluded and would benefit from letters and phone calls.  We suggest that further clarity could also be added to the quality statement to ensure that the aim of inviting and encouraging patients to accept the offer of vaccination. The word ‘contacted’ is vague and we suggest amending this to ‘invited and encouraged to receive a flu vaccination.’  This statement should be achievable for local services and it will already form part of many providers’ routine planning for delivery of the flu programme. The use of a combination of contact methods is advocated in several national guidance documents, for example the Flu Plan for Winter 2017/18 and the Flu Vaccination Programme Delivery Guidance 2018/19 from Public Health England, NHS England and the Department of Health, as well as the 2018 NICE guidelines. |
|  | British Society for Immunology | 1 | Where possible, invitations should be personalised as this has been shown to increase their effectiveness. |
|  | British Society for Immunology | 1 | Social media invitation should be defined – an advert may be less effective and more difficult to message versus a direct message. Do GPs collect patients’ social media details? Thought should also be given to the different social media platforms and if/how they are used by the target audience. |
|  | British Society for Immunology | 1 | Some communities might have specific questions about the flu vaccine relevant to them e.g. some Muslim communities and questions around the use of gelatine in flu vaccines. Efforts should be made where possible to target the information or direct to further resources in the invitation to cover any areas of concern relevant to the local community. |
|  | British Thoracic Society | 1 | Page 4, Introductory paragraph, Line 5, insert ‘include’ between ‘and’ & ‘any’. |
|  | British Thoracic Society | 1 | Page 5, ‘Outcome’, insert ‘Optimum’ at beginning of sentence. |
|  | British Thoracic Society | 1 | Page 6, under Commissioners, line 2, insert ‘who is eligible’ between ‘everyone’ and ‘to’ and after ‘vaccination’ delete ‘who is eligible’. |
|  | Carers Trust | 1 | Carers should be added to the list of groups that are underserved by the flu vaccinations programme.  Evidence shows that only 40% of England’s unpaid carers were vaccinated against the flu in 2017/18 – a decrease from the figure in 2016/17 (https://psnc.org.uk/our-news/identifying-carers-and-care-workers-eligible-for-a-flu-vaccination/)  The benefits of getting a free flu jab are applicable to all carers, regardless of their age or the health and support needs of the person or people they care for. The benefits of providing a flu jab to unpaid carers are already recognised by NICE in several of the documents used to develop the Quality Standards, for example, the NICE Guidelines on Flu Vaccination: Increasing Uptake, and the Influenza Green Book.  • If a carer gets flu, the person they care for will need extra support, which may put extra pressure on NHS and social care services. Getting a flu jab will protect the carer from flu, thereby reducing the risk of the person with care and support needs accessing emergency care.  • Keeping the carer well helps protects at least two vulnerable people as many carers may care for more than one person.  • It gives carers a chance to see a healthcare professional and let them know about their caring role. |
|  | Department of Health and Social Care | 1 | This statement could be strengthened to emphasis recall of patients who have not responded to the invitation to have the flu vaccine |
|  | Department of Health and Social Care | 1 | The rationale says: “Initial invitations and reminders for overdue vaccinations can be in writing (letter, email or text message), by phone or social media, or using a combination of these methods to maximise vaccine uptake.” It would be helpful to specify what is meant by “social media”. For example, this should not include a notice on the GP Practice’s Twitter/ Facebook page, but could include a direct message to the patient. |
|  | Department of Health and Social Care | 1 | Any written communication under this QS should include the offer of a phone-call or face to face discussion with a healthcare professional, to answer any questions. |
|  | NHS England and NHS Improvement | 1 | Please add ‘All’ to the start of the statement, this will help us establish a clear measure based on an agreed ‘baseline’ for each eligible group. (RA) |
|  | NHS England and NHS Improvement | 1 | To Rationale add text to reflect current terminology :  Invitations (Call) for flu vaccination are more effective…. Follow-up (Recall) will help to prompt those who are eligible for vaccination  Structure: … Evidence of local arrangements to ensure that people in eligible groups receive invitations when their flu vaccination is due or overdue. (Call and Recall) (RA) |
|  | NHS England and NHS Improvement | 1 | Quality measures & Data sources: NB These apply to all standards  Before implementation it will need to be established if there be the capacity within the GP IT systems for this? And If there is an agreed ‘data set’ for each ‘at-risk’ group in the Under 65 cohort with NHS Digital? (RA) |
|  | NHS England and NHS Improvement | 1 | Proportion of people in eligible groups who receive social media invitations when their flu vaccination is due or overdue.  Need to establish ifl there be the capacity within the GP IT systems for this and for ‘counting’ each type/method of communication and establish and agreed ‘data set’ with NHS Digital? (RA) |
|  | NHS England and NHS Improvement | 1 | Page 6 – Quality statement  Providers contact people - Will this apply to all Providers? May be difficult for Community Pharmacies, is the statement predicated on the basis that GPs are seen as the Provider? (RA) |
|  | NHS England and NHS Improvement | 1 | Page 6-7  Suggest list all of the clinical at risk groups from the Green Book (RA) |
|  | NHS England and NHS Improvement | 1 | Page 7-8 for the addition underserved groups listed this be stronger these people should be able to access a General Practice service for their healthcare needs and from this be invited as per this proposed Standard  NB: This applies to all standards (RA) |
|  | Primary Care Respiratory Society | 1 | Is there evidence to support that statement that invitations are more effective when delivered in a variety of ways? It may be that too many messages might turn people off. But agree that message should be given to an individual in a format that is appropriate and useful for that individual. And messages should be the same which ever way they are conveyed to prevent dissonance |
|  | Primary Care Respiratory Society | 1 | “Numerator o the number of people in the denominator who receive written invitations” Can receipt always be confirmed or should this be “ who are SENT written invitations”? |
|  | Primary Care Respiratory Society | 1 | “What the QS means for commissioners” Social media may not be an appropriate way to ensure people are invited for vaccination but may have some utility in backing up to another method of communication or raising awareness. |
|  | Public Health England | 1 | This is an important quality standard because there is good evidence that actively inviting patients, through a personal invitation for flu vaccination increases uptake. Patients in “at-risk” groups generally have lower flu vaccine uptake than the over 65s with many people in at risk groups not aware that they are eligible for flu vaccination. There is also variation between practices. For parents of children aged two and three years old, the programme is relatively new (introduced in 2013) and if the child is the first born in the family, parents may not be aware that they are eligible for flu vaccination.  Collection of this data should not be onerous and could be incorporated into local assurance processes. It is a requirement of the general practitioner (GP) Direct Enhanced Service specification that a proactive call and recall system is developed to contact all at-risk patients:  www.england.nhs.uk/wp-content/uploads/2019/03/dess-sfl-and-pneumococcal-1920.pdf |
|  | Royal College of General Practitioners | 1 | The committee should consider the impact that measuring the variety of contact methods may have in primary care, especially if there is in incentive scheme attached to the data collection.  • The correct mode of communication, appropriate for the practice population that increases flu uptake is more important than pushing for multiple modes of communication.  • There is a potential risk of incentivising the deliberate sending of multiple and unsuitable forms of invites, just to meet a performance measure, without focusing on achieving improvement in inequality/diversity/access issues. |
|  | Royal College of General Practitioners | 1 | Can the committee consider adding to the statement “appropriate to their individual needs” so it reads: “People in eligible groups are contacted about the flu vaccination using a range of methods appropriate to their individual needs” |
|  | Royal College of Paediatrics and Child Health | 1 | Do systems record how an invitation is sent and the preferences of individual patients? Should the denominators be the number of people who requested a particular way in which they should receive information or is the fact that it is the total eligible population an indication that this information is not known. While not ideal, this would be better than nothing. If one does not know what proportion of people have opted for a particular mode of communication, how can one know what is good?  Difficult to determine “Proportion of people in eligible groups who receive written invitations (letter, email or text message) when their flu vaccination is due or overdue.” How can you be sure people have received? May have moved etc. Better as proportion of people etc who are SENT invitations’ – same applies to phone calls and social media. |
|  | Royal College of Paediatrics and Child Health | 1 | This should read “People who… flu vaccine or those with parental responsibility, receive invitations….” |
|  | Royal College of Physicians of Edinburgh | 1 | Invitation for vaccination  The invitation method should be ideally suited not just to the target group as a whole – but to the individual. Some recent research in Scotland commissioned by NHS Health Scotland indicated that this was important to patients. Some want an email, a text, some a telephone call etc. http://www.healthscotland.scot/media/2492/exploring-public-views-of-vaccination-service-delivery.pdf  More consideration should also be given to opportunistic invitations – such as ‘every contact counts’. |
|  | Royal Pharmaceutical Society | 1 | Currently if a community pharmacy contacts a person regarding their flu vaccination and invites them to have one, this data is not necessarily collected and collated locally or nationally. Processes would need to be put in place to enable this to happen in a structured way. Such processes should be electronic, easy to access, embedded within the pharmacy systems and not place undue burdens on those working in a community pharmacy or remove them for proactively engaging with people |
|  | Sanofi Pasteur | 1 | The intention for all eligible patients to be invited to receive a flu vaccine, using a variety of appropriate methods is positive, but must include secondary care and community settings to maximise uptake. The success of this statement could be increased by the opportunistic contacts for flu vaccination existing at routine planned secondary care appointments (especially for services such as Maternity) and improve capacity in primary care. |
|  | Sanofi Pasteur | 1 | Use of ‘or social media’ may lead to confusion. A possible better statement is ‘and social media’ as this may imply exclusive social media use is a sufficient communication medium |
|  | Sanofi Pasteur | 1 | This may be hard to measure unless clarity is provided on what ‘social media invitations’ are, and which channels would be considered appropriate. |
|  | Sanofi Pasteur | 1 | The use of social media as a medium of invitation may not be specific enough to achieve the intention of a tailored invite within statement 2 |
|  | Sanofi Pasteur | 1 | In order to improve the uptake of influenza vaccine, there needs to be a desire to order increased vaccine stock in order to achieve the Public Health England ambition of 75% coverage. Situations may arise with improved and tailored invitations where stock is limited if initial orders are not sufficient. |
|  | Association of Respiratory Nurse Specialists | 2 | We believe better literature would be useful, myth busting the negative effect of Flu vaccination and explaining clearly the benefits to individual groups in appropriate language i.e. asthma patients may appreciate a different approach as predominantly younger to an older generation. Pharmacy's see those at risk, under 65s, especially asthmatics on regular basis so can work to reinforce the message and importance of having the flu vaccine for that particular group. Good news stories, accentuating the positive rather than dwelling on negative stories such as vaccine shortage, no appointments; who gets paid etc.  Posters reminding people to cancel existing appointments at GP surgery if they are seeking vaccination there and then at the pharmacy would ensure appointments are maximised. |
|  | Asthma UK | 2 | As people with asthma are part of the identified clinical at-risk group, the information included about their clinical risk is crucial. Improving the information available to people with asthma when contacted about the flu vaccination could help improve uptake. Despite extensive information campaigns, our experience of talking to people with asthma is that many do not always understand how their asthma makes them more at risk from the effects of influenza. We have also heard some unfortunate stories of being admitted to hospital for asthma-related problems shortly after receiving their flu jab. While highly likely to be unrelated, this is a potential fear for people with asthma, in addition to other potentially sceptical attitudes towards vaccinations. Without clear information to dispel a link between hospitalisation for respiratory problems and receiving the flu jab, people in at risk groups could be deterred from getting the jab.  In winter 2018/19, Asthma UK helped promote the necessity of the flu jab. However, more needs to be done reach people with asthma. We appreciate that there are current arrangements in place to target different groups, but with only 48% of those in at risk groups immunised in winter 2018/19 (https://www.gov.uk/government/statistics/annual-flu-reports) further efforts are needed. Tailored information is needed to emphasise the need for people with asthma to receive their vaccination. |
|  | British Lung Foundation | 2 | We warmly welcome this statement and believe it reflects a key area for quality improvement. Evidence suggests that one of the reasons people in eligible groups do not get the vaccine is because they do not think of themselves as being at-risk or susceptible to flu or that they are ‘healthy’ and do not need the vaccine (see Santos AJ et al. “Beliefs and attitudes towards the influenza vaccine in high-risk individuals.” Epidemiology and Infection 145, 9: 2017). Sending invitations that include tailored information about a patient’s specific condition and risk, for example that because of their asthma they may suffer complications if they contract flu, is likely to be more effective than a generic letter.  Studies have shown that patients who receive information from a trusted health professional are more likely to get vaccinated. Such information-sharing could take the form of a brief intervention, for example when eligible patients register with a GP, when they book and attend clinical appointments or when they visit community pharmacies. Patients with chronic respiratory conditions may already be in regular contact with primary and/or secondary care, which presents existing opportunities to intervene. We would therefore welcome the addition of a specific line to the ‘What the quality statement means for different audiences’ section to encourage health care professionals to provide face-to-face information about flu vaccination at every opportunity, rather than just at the invitation stage. For example: ‘healthcare practitioners invite people in eligible groups to receive flu vaccination and provide information and advice on vaccination at every opportunity which is relevant to the person’s individual situation or clinical risk.’ This could also help tackle any misconceptions about the vaccine which may deter people in eligible groups from receiving the vaccine. Two recent British Lung Foundation Facebook posts on the flu vaccine elicited comments from patients who believed that the vaccine has previously given them flu or that it does not work. This highlights that there is a need to address myths and misinformation about flu and the vaccine.  We would also suggest that the patients’ ‘situation or clinical risk’ is as tailored as possible. Condition-specific messaging is likely to be more effective. For example, this should involve referencing a patient’s asthma or chronic obstructive pulmonary disease, rather than their ‘respiratory condition.’  The implementation of this statement may require some additional time and resources initially, but a personalised approach will be more likely to engage patients with flu vaccination and therefore produce long-term benefits. Service providers should ensure that existing IT systems identify eligible patients and tailor invitations accordingly, and that patient records provide a prompt to staff to offer vaccination. The service specification for general practice already recommends that at-risk patients be ‘called’ and ‘recalled’ for immunisation. |
|  | Care England | 2 | The process of identifying those eligible the flu vaccine may be complicated by the past lack of clarity/misinformation regarding whom was eligible. We suggest, that future resource allocations should take account of how historical treatment and implementation regarding the flu vaccine has shaped the current realities and underlying perceptions of social care staff. |
|  | Care England | 2 | We believe that Care England and other trade associations are acutely aware of the contextual realities which will likely affect the future development implementation of such responsibilities. Thus, in order to facilitate the effectiveness of these quality standards going forward that trade associations should be involved in the planning going forward. |
|  | Carers Trust | 2 | Carers should be added to the list of groups that are underserved by the flu vaccinations programme.  Evidence shows that only 40% of England’s unpaid carers were vaccinated against the flu in 2017/18 – a decrease from the figure in 2016/17 (https://psnc.org.uk/our-news/identifying-carers-and-care-workers-eligible-for-a-flu-vaccination/)  The benefits of getting a free flu jab are applicable to all carers, regardless of their age or the health and support needs of the person or people they care for. The benefits of providing a flu jab to unpaid carers are already recognised by NICE in several of the documents used to develop the Quality Standards, for example, the NICE Guidelines on Flu Vaccination: Increasing Uptake, and the Influenza Green Book.  • If a carer gets flu, the person they care for will need extra support, which may put extra pressure on NHS and social care services. Getting a flu jab will protect the carer from flu, thereby reducing the risk of the person with care and support needs accessing emergency care.  • Keeping the carer well helps protects at least two vulnerable people as many carers may care for more than one person.  • It gives carers a chance to see a healthcare professional and let them know about their caring role. |
|  | Department of Health and Social Care | 2 | Information should not be limited to why the vaccination is important to people with certain clinical risk groups, but it should also seek to counter concerns that the vaccine may be dangerous to people with certain conditions, including pregnant women. This is particularly important with the recent proliferation of online disinformation about the harms of vaccines. |
|  | NHS England and NHS Improvement | 2 | Please add ‘All’ to the start of the statement, this will help us establish a clear measure based on an agreed ‘baseline’ for each eligible group. (RA) |
|  | NHS England and NHS Improvement | 2 | Suggest new text and that production of some information can be done once at a national level and be made available to use locally and this would be more cost effective.  Evidence of national and local arrangements to create information tailored to different types of eligibility for the flu vaccine. (RA) |
|  | NHS England and NHS Improvement | 2 | Page 9-10  Data statements – comments on GP IT systems and data sets also apply here (RA) |
|  | NHS England and NHS Improvement | 2 | Page 10 Inviting eligible people: How do we ensure that there is no duplication of activity in inviting people across all those mentioned – should the lead be given to General Practice? (RA) |
|  | NHS England and NHS Improvement | 2 | There is potential need for increased resource to develop tailored advice – I would recommend national or commissioner based template production for specific clinical scenarios would be beneficial to ensure equity of information, this should be made available in a variety of languages and formats – the cost would be prohibitive for small providers and could lead to a failure if required to develop individually and also gives scope for error or poor communication. (YK) |
|  | Primary Care Respiratory Society | 2 | “Rationale: …people in eligible groups to understand the benefits of having the flu vaccine” Will this be individualised? How will clinical risk for assessed. What about individuals in more than one risk category? This could be very complicated |
|  | Public Health England | 2 | Tailored information for at risk patients is important. Historically, only around half of those in at risk groups get the flu vaccine despite the increased risk they are at of getting severe complications from flu. While patients aged 65 and over have good uptake levels and tend to take responsibility for ensuring they get their flu vaccine every year, many people in at risk groups may not be aware that they are eligible for flu vaccination. This is particularly the case when they have an underlying health condition which is well managed, they may not be attending their GP practice often, and they do not perceive themselves to be at risk.  Page 4 of the influenza chapter of the ‘Green Book’ (chapter 19) sets out the increased risk of mortality from flu for those in clinical risk groups: www.gov.uk/government/publications/influenza-the-green-book-chapter-19. For many patients they may not be aware that their condition puts them at increased risk from flu. For instance, for those with liver disease are 48 times more likely to die from flu but they will often not be aware of the elevated risk.  The identification of these patients can be done through GP records. |
|  | Royal College of General Practitioners | 2 | Ensuring invitations for flu has the reason they are eligible for the vaccination is good in principle however, the committee should consider the increase in workload for primary care to add this detail to the written invitation (letter, text or email). IT support may need to be in place to extract this data easily from records and consideration to this should be taken into account when adding this to the quality standard. |
|  | Royal College of Paediatrics and Child Health | 2 | This is excellent, but are GP systems good enough to allow one to invite a person with, for example, end stage kidney disease? How much detail is possible? Not at-risk patients identified by age cohort is easy, but at-risk groups, perhaps not so.  There is the potential for causing distress to patients – is there evidence that this approach is effective? |
|  | Royal College of Paediatrics and Child Health | 2 | Should this read “children who are not eligible by reason of being at risk, but by age. The minimum age is 2 years. For upper age limit consult contemporary ‘flu letter.” |
|  | The Royal College of Physicians and Surgeons of Glasgow | 2 | Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Most general practices have systems in place to contact those who are registered. However not everybody has a GP. This includes homeless and travelling people. Many General Practices do not have a system where they make sure Care and nursing homes are covered in a systematic way.  As stated above, those most at risk may be the most difficult to contact. A variety of methods need to be used including personal visiting when someone fails to answer.  The groups eligible seems to have omitted those people over 65 years.  Many primary care practices are not aware of the up to date eligibility groups. In particular it is very common for those on immunosuppressants but without malignancy to be told they are not eligible. Practices do not necessarily update their staff. |
|  | Royal College of Physicians of Edinburgh | 2 | Information on vaccination  The College strongly supports this statement and indicators. NHS Health Scotland research indicated this was an area which was lacking. Patients did not really see why a flu vaccine was applicable to them and would welcome more tailored information. |
|  | Royal Pharmaceutical Society | 2 | If a community pharmacy provides tailored information to a person eligible for flu vaccination, this information is currently not captured. Processes will need to be put into place so that this information can be captured and shared in a timely manner, see above. |
|  | Sanofi Pasteur | 2 | This statement could be better accomplished by the appointment of a named, responsible flu champion within organisations who would drive the flu programme throughout the season. |
|  | Sanofi Pasteur | 2 | The intention for all eligible patients to be invited to receive a flu vaccine, using a variety of appropriate methods, including information on why it is important for them is positive, but must include secondary care and community settings to maximise uptake. The success of this statement could be increased by the opportunistic contacts for flu vaccination existing at routine planned secondary care appointments (especially for services such as Maternity) and improve capacity in primary care. |
|  | Sanofi Pasteur | 2 | The encouragement of frontline health and social care staff to receive their flu vaccination from their employer is positive. Invitations for vaccination of health and social care staff need to be detailed and tailored as per quality statement 2 to ensure uptake and reduce vaccine hesitancy. |
|  | Sanofi Pasteur | 2 | In order to improve the uptake of influenza vaccine, there needs to be a desire to order increased vaccine stock in order to achieve the Public Health England ambition of 75% coverage. Situations may arise with improved and tailored invitations where stock is limited if initial orders are not sufficient. |
|  | Association of Respiratory Nurse Specialists | 3 | Online recording of those that have been vaccinated that can be viewed by all would be an easier way of capturing those not vaccinated by their GP. The responsibility to input the vaccine and lot numbers etc. would be on the provider rather than notifying individual surgeries?  A better reporting system from pharmacy, currently they have to inform the GP who they have vaccinated but the GP still has to input and code making it onerous and likely information may be missing.  Giving the same message with the same identifiable slogan and images ie 'protect Plymouth from flu' giving it a community ownership type of slant, this could be replicated in GP and pharmacy’s and also advertised on buses, libraries shops, local radio etc. Making the campaign more localised with a common slogan/style may interest more to take up the offer.  PCNs meeting with their pharmacy's and discussing ways to collaborate to increase whole uptake rather than their own which benefits the whole community and again makes it more local to people. |
|  | Asthma UK | 3 | We support the collection of accurate data, and recognise the need to share data on vaccine uptake in a timely and secure manner. We support the provision of vaccines outside of GP surgeries (such as in pharmacies, schools and care homes), and data on this activity must be shared with the patient’s GP. Sharing this data will also avoid the duplication of work in targeting those already vaccinated.  In order to better target those in specific at risk groups, we recommend data collection by the condition that puts one at risk. Currently, data on all those in a clinical risk group are presented together. Those in at risk groups are a diverse group, and being able to find out the proportion of people with asthma (and in other groups) who received the flu vaccine would allow better targeting and planning of services and campaigns. |
|  | British Lung Foundation | 3 | Accurate recording of vaccination status in non-GP settings is important to capturing a full picture of uptake and for future vaccination programme planning. We support this quality standard and recognise that it will require a level of joined-up planning between providers at a local level.  One vaccination setting of particular importance for patients with respiratory disease is community pharmacy. More than 1.6 million people visit a community pharmacy every day and according to the Pharmaceutical Services Negotiating Committee, 89% of the population in England has access to a community pharmacy within a 20-minute walk. Accessibility can be a barrier to vaccination and pharmacies offer an alternative setting to receive vaccination, without requiring a GP appointment. This may be particularly useful for working age people or people who are away from home, for instance to care for a relative, and so cannot get to a GP appointment.  Pharmacy is seen as vital to delivering many of the commitments in NHS England’s Long Term Plan and we should expect to see a bigger role for pharmacists in future. With this will be more opportunities to speak with patients about their condition, self-management and receiving the flu vaccination. |
|  | British Lung Foundation | 3 | NHS Digital’s new data sharing standards will allow pharmacists to share data on patients’ flu vaccination status with GPs easily and promptly. The standards were first published in November 2018 and NHS Digital are engaging with IT suppliers to roll these out more widely. This rollout is expected to take place by the end of 2019, and it will substantially improve pharmacy and GP providers’ ability to implement this quality standard. |
|  | British Society for Immunology | 3 | If social media invitations are by advert, then what provisions are there in place to prevent people being invited more than once? |
|  | British Society for Immunology | 3 | As well as targeting settings outside the GP surgery where patients might receive a flu vaccine, thought should also be given to making ‘every contact count’ within the GP surgery too. If the patient has an appointment at the surgery for an unrelated reason, the GP/nurse should check their flu vaccination status and offer them a flu vaccine at that appointment if they are unvaccinated. |
|  | Care England | 3 | This may difficult given the current technological differences and obstacles which remain in place between the social care sector and the NHS. For example, our members in their feedback to Care England reflected upon the current difficulties of the care and health sectors joint use of NHS mail to facilitate greater cooperation. |
|  | Care England | 3 | The specific responsibility of providers to engage in a way which “information is shared in a timely, accurate and consistent way” maybe affected by the plethora of resource aspects. This includes the high vacancy rates currently evident in the social care sector, including, the 11.8 percent vacancy rate for care home mangers. Such realities may lead to a lack of leadership surrounding such processes, thus, we suggest that there needs to be clarity surrounding whom in specifically given responsibility. |
|  | Care England | 3 | One may also reflect upon the specifically high turnover rates that are evident in the social care sector. For care workers this has been at around 27 percent, thus, this may have specific ramifications for the ability of providers to implement such processes. Such high turnovers may lead some to be relatively unaware of the communications processes cited when juxtaposed with other sectors. Also, affecting the number of individuals with such levels of information sharing in the coming years. |
|  | Care England | 3 | The number of providers whom are shutting their doors is continuing to rise, for example, a Hft 2018 sector pulse check found that 68 percent of organisations said that they envisaged having to close down some parts of their organisation in the near future. We believe, that the instability of providers should be considered in the future implementation of such communications processes. |
|  | Care England | 3 | One may consider the different workforce realities and variance between the social care and health sectors. Including, varying educational and training levels which on average occupy different sector. The implementation of the quality standards may in turn be complicated in the social care sector. |
|  | Carers Trust | 3 | Carers Trust welcome the inclusion of this quality statement on information and that “People in eligible groups who have the flu vaccine in a setting other than their GP surgery have their vaccination status shared with their GP.”  The Rationale for this quality statement should include information about which eligible group the patient belongs to. This could have the advantage of identifying people who are eligible but do not necessarily have a medical condition – such as carers. |
|  | NHS England and NHS Improvement | 3 | Please add ‘All’ to the start of the statement, this will help us establish a clear measure based on an agreed ‘baseline’ for each eligible group. (RA) |
|  | NHS England and NHS Improvement | 3 | Page 13: People in eligible groups who have the flu vaccine in a setting other than their GP surgery have their vaccination status shared with their GP  Comment There will need to further investment in IT systems and interoperability to ensure effective transfer of data and does not increase burden of data management on GPs (RA) |
|  | NHS England and NHS Improvement | 3 | Page 13  Quality measures structure: National standard solutions should be put in place with GP IT and other system suppliers to ensure quality and consistency of data to support effective monitoring. Local solutions could lead to variation and inconsistency. (RA) |
|  | NHS England and NHS Improvement | 3 | Page 13  ImmForm should be seen as the agreed national monitoring system which uses data form GP systems to provide both local and national data (RA) |
|  | Primary Care Respiratory Society | 3 | “Information Sharing. Need to capture information on non-GP vaccinations but could the metric be simplified with deletion of Denominator ? There is a need for this information of course and a figure based on the overall volume of vaccines from non-GP providers is a meaningful metric but unclear on usefulness of a Denominator ("number of non-GP providers") which may hide some good performing non GP practises ? Would two separate metrics be more viable ? |
|  | Primary Care Respiratory Society | 3 | What about in situations where electronic record sharing is suboptimal? This sounds like lots of work for both the alternative provider and the GP. If vaccination takes place in the work place, a patient may not want to share their health record with their employer? |
|  | Public Health England | 3 | This is an important quality standard because whilst the majority of flu vaccination takes place in general practice, it may also be offered in community pharmacies, schools, maternity services and secondary care. GP practices need to hold accurate records of patients who may have been offered the flu vaccine in these settings for clinical reasons (such as any adverse events) and to avoid inadvertently vaccinating a patient twice. |
|  | Royal College of General Practitioners | 3 | Sharing of information between health care providers now has to be approved by the patient. The committee should consider adding “with patient consent” or equivalent to the quality standard to ensure this meets current GDPR and information sharing guidance. |
|  | Royal College of Paediatrics and Child Health | 3 | Should the patient not receive a record of what they have been given. This is especially important for those previously noted to be underserved as they are highly mobile and may not always be registered with a GP. |
|  | Royal College of Paediatrics and Child Health | 3 | Should there be evidence that when the GP receives the notification it is entered, in an easily retrievable manner, on the GP IT system. |
|  | Royal College of Paediatrics and Child Health | 3 | If patients are given a record, this will help ensure they are not given extra doses. |
|  | Royal College of Physicians of Edinburgh | 3 | Information sharing    Sharing information in a timely way during flu vaccination season is challenging and this statement seems reasonable. |
|  | Royal Pharmaceutical Society | 3 | For information sharing to take place there needs to be electronic processes in place that enable this to happen in a safe and effective way, e.g. from a community pharmacy to a GP practice. These are being progressed by NHS Digital and The Professional Records Standards Body and need to be embedded into pharmacy systems to ensure ease of use. GP systems need to be enabled to accept the information that is being shared with them. |
|  | Sanofi Pasteur | 3 | The support for all flu vaccination providers sharing their data with GPs is very positive, but it needs to be clear how that system will work, who will design and implement it, and will it be adequately resourced. Current IT infrastructure indicates that only 40% of GP systems can receive the information from pharmacy. (https://www.pharmaceutical-journal.com/news-and-analysis/news/fewer-than-half-of-gps-will-be-able-to-receive-patient-flu-data-from-pharmacy-this-autumn/20206835.article Accessed 03/09/2019). |
|  | Sanofi Pasteur | 3 | This statement may benefit from the addition of ‘…vaccination status shared and recorded with their GP’ as the status may be shared but there is no obligation for this to be coded in the patients’ health record. |
|  | Association of Respiratory Nurse Specialists | 4 | Information targeted at the benefits of vaccination for staff, myth busting as per statement 1. Vaccination available at drop in clinics, across multiple sites to make access easier. Targeted areas such as respiratory, ED etc. |
|  | Asthma UK | 4 | The commitment to providing flu immunisation for NHS staff is crucial to stopping the spread of the disease. However, we feel that the coverage suggested in the quality standard should go beyond just those who have contact with patients. This could include administrators, cleaning staff and those working in hospital catering. Extending coverage to all who work in health and social care could help stop the spread of influenza.  A further source of unmet need for flu immunisation may be in those caring for people with long term conditions, either as parents or for those unable to work due to their condition. This group may expose those at risk groups – such as people with asthma – to infection. They are not provided with free vaccinations, and may not be able to afford to access it outside the NHS. We recognise that identifying and contacting this group (as well as collecting data on uptake) may prove challenging. |
|  | British Lung Foundation | 4 | We support this quality statement and view the vaccination of front-line health and social care staff as a vital area for quality improvement. Staff should be vaccinated to avoid passing flu to their patients who may be more vulnerable to its effects, to protect themselves, their families and their colleagues. Health care staff are more likely to be exposed to flu than the general public, with an estimated one in four workers becoming infected in a mild flu season. Last year, the Government set an ambition of 75% of frontline health care staff to receive the vaccine and came close to this target, with 70.3% getting the vaccine.  Health and social care staff are not routinely eligible for vaccination through the national free vaccination programme. It is instead considered an occupational health responsibility for the NHS and social care employers to fund staff vaccination. Whilst the programme for NHS staff is well funded and planned, the social care programme lags behind. It is likely much less likely that a consistent programme is undertaken for social care staff vaccination across the many organisations in the social care sector. The vaccination programme was therefore extended to some social care staff in England in 2017, funded by NHS England, and continued and expanded in following years. We would like Government to provide sustainable funding for social care staff flu vaccination, recognising that maintaining this as an employer responsibility will likely not achieve the desired uptake rates. We therefore recommend amending the quality statement to ‘from their employer or Government.’ |
|  | British Lung Foundation | 4 | We fully support the collection of data on social care worker vaccination. No data is currently collected in England, Scotland or Wales, so it is unknown how many social care staff currently receive the vaccine. The recommendation for local services to evidence implementation of the quality standard through process measure b (‘proportion of social care workers with direct contact with people using services who receive the flu vaccination’) is therefore very welcome.  Establishing such data collection may be initially burdensome but is essential for planning future flu programmes. The House of Commons Science and Technology Committee questioned the Secretary of State and the National Medical Director of NHS England about the lack of data collection system for social care and in response were informed that ‘the principle challenge is the nature of provision in the social care sector, with large numbers of small independent providers, from which data collections would need to be established’ (available here: https://www.parliament.uk/documents/commons-committees/science-technology/Correspondence/190220-Professor-Stephen-Powis-to-Chair-re-Flu-vaccination-programme-in-England.pdf). An electronic data collection service would need to be established, alongside support for effective use of the system.  We also support the decision to include quality measures which breakdown health care professional uptake by occupation, as there is significant variation between different roles. |
|  | Care England | 4 | We received feedback which suggested a lack of awareness within some parts of the NHS workforce of the fact that, in the last two winters, independent sector frontline staff have been entitled to receive a free flu vaccination. |
|  | Care England | 4 | Multiple feedback sources also noted how flu jabs in their view did not become available in 2017/18 until too late in the winter period. Saying, “The jabs were not available early enough in the winter period and it was not initially clear where they could be obtained.” |
|  | Department of Health and Social Care | 4 | We agree that there should be a specific QS for health and social care workers. The wording in the statement which includes “people using services” is not very clear. It would be made clearer that health and social care workers who have direct contact with vulnerable groups are vaccinated. |
|  | Department of Health and Social Care | 4 | It should be made clear that “social care workers including hospice workers” are covered by this standard. |
|  | NHS England and NHS Improvement | 4 | Please add ‘All’ to the start of the statement, this will help us establish a clear measure based on an agreed ‘baseline’ for each eligible group. (RA) |
|  | NHS England and NHS Improvement | 4 | Suggest that this should also apply to the over 65’s and that the opening page states: (RA)  This quality standard covers increasing the uptake of flu vaccination among people who are eligible. It describes high-quality care in priority areas for improvement. It does not cover uptake of flu vaccination in people aged 65 and over, with the exception of Statement 4 (RA) |
|  | NHS England and NHS Improvement | 4 | Page 16  Agree with statement.  Agree, suggest that this is included within CQC inspections and registration under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 including ‘Providers must prevent and control the spread of infection’ https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment  Will need clear an agreed definition and baseline for Social Care Workers and also for Healthcare Workers as currently NHS Trusts count differently i.e. some include ‘Facilities management’ staff such as Porters and Catering and others do not (RA) |
|  | NHS England and NHS Improvement | 4 | Page 16  Quality measures: All monitoring needs reflect current national approach link to ImmForm and supporting NHS and GP IT systems. (RA) |
|  | NHS England and NHS Improvement | 4 | Page 18: We recognise that employers may use ‘various means to encourage and facilitate uptake’ this will require effective linkages to be made to the GP IT systems to record patient details and be linked to ImmForm with supporting data sets agreed. (RA) |
|  | NHS England and NHS Improvement | 4 | Making this clearly an employers responsibility will mean that NHS England may ‘stand down’ the current complimentary scheme currently operating. (RA) |
|  | NHS England and NHS Improvement | 4 | Quality statement 4: Vaccinating health and social care staff  Clarity needs to be given about the need for vaccination to be directed to patient facing staff – the whole population of staff in a patient facing organisation benefit from immunisation as an outbreak will affect all staff and impact service delivery and care – the standard should reflect the need for organisational policies in patient facing organisations to be appropriate rather than a focus on numbers of staff immunised. Priority must be direct contact staff and data collection should reflect that. (YK) |
|  | Public Health England | 4 | Evidence of local arrangements to increase flu vaccine uptake in frontline health and social care workers is important because we know that making vaccination easily accessible is key in improving flu vaccine uptake. National Health Service Trusts are already required to collect data on their eligible population and the numbers receiving flu vaccination as part of national data collection and can use this data to identify where target efforts to improve uptake (e.g. different professional groups). In social care there is no national data collection requirement with many organisations not collecting information on their denominator or staff uptake. Collecting this locally is an important step to assessing uptake in their population. |
|  | Royal College of General Practitioners | 4 | The committee should consider adding “or nominated deputy” to the statement so it reads:  “Health and social care staff who have direct contact with people using services receive flu vaccination from their employer (or nominated deputy)”  Some health and social care staff receive their flu vaccine from pharmacies or GPs under NHS terms e.g. care/nursing home staff. The NHS does not provide an occupational health service, and this is not part of the General Medical Services (GMS) contract. Whilst hospitals/trusts have their own or contract for Occupational Health, smaller organisations often do not have this available. |
|  | Royal College of General Practitioners | 4 | Simply measuring the number of health and social care staff through employers will yield an inaccurate result unless all staff members have to declare if they have had the flu vaccination elsewhere. E.g. through their own GP due to a long term condition. From a disclosure, GDPR and information sharing perspective this will be very difficult to enforce. |
|  | Royal College of Paediatrics and Child Health | 4 | Should commissioners include local authorities as they frequently commission outside providers for residential homes, home helps, etc.? |
|  | Royal College of Paediatrics and Child Health | 4 | Should it read “…-based care services (including clinics and to people in their own homes)..”, otherwise it implies that community-based is only people in their own homes. |
|  | Royal College of Physicians of Edinburgh | 4 | Vaccinating health and social care staff  ‘Evidence of local arrangements to make flu vaccination available to Health care workers (HCWs’) is a very minimum standard. Something more challenging would be welcome to demonstrate good local arrangements which facilitate ease of access by HCWs at numerous points in the system – at night, in the community, no waits, roving clinics, peer vaccinator etc.    The NHS employers flu fighter campaign has a wealth of ideas here https://www.nhsemployers.org/flufighter    It would be beneficial to target specific areas of healthcare such as oncology, haematology etc where particularly high uptake would be welcomed – rather than just ‘direct contact with patients’ However it is acknowledged that in the current climate where there is much cross cover of staff to fill vacant slots on busy wards this might not be as beneficial    Equality and diversity considerations should include prisoners and the housebound (i.e. unable to attend their GP practice) |
|  | Royal Pharmaceutical Society | 4 | Employers of pharmacists should offer the vaccine to their staff free of charge. |
|  | Sanofi Pasteur | 4 | This statement could be better accomplished by the appointment of a named, responsible flu champion within health and social care organisations who would drive the flu programme throughout the season. |
|  | Sanofi Pasteur | 4 | The encouragement of frontline health and social care staff to receive their flu vaccination from their employer is positive, but it needs to be coupled with clear messaging on why it is important. Invitations for vaccination of health and social care staff need to be detailed and tailored as per quality statement 2 to ensure uptake and improve vaccine confidence.  This may also serve to reinforce staff recommending vaccination to peers and patients. |
|  | Sanofi Pasteur | 4 | In order to improve the uptake of influenza vaccine, there needs to be a desire to order increased vaccine stock in order to achieve the Public Health England ambition of 75% coverage. Situations may arise with improved and tailored invitations where stock is limited if initial orders are not sufficient. |
|  | Sanofi Pasteur | 4 | Current levels of vaccination in secondary care have risen as a result of the national CQUIN. In order to have the same impact in primary care, a similar amount of resourcing would be needed in primary care. |
|  | Sanofi Pasteur | 4 | Measurement and definition of ‘support staff with direct contact with people using service’ in primary and secondary care may be difficult despite the definition in the terms used within the quality statement as it may exclude clerical staff involved in the scheduling and support of services. |
|  | St John Ambulance | 4 | The provision of flu vaccinations to St John Ambulance operational people whether volunteer or employed is challenging; this year an awareness campaign is planned to start in September and the arrangements that are in place communicated more widely than before. In our small nursing home, trained nurses are being given vaccination training to enable them to vaccinate the staff there (vaccinations will be supplied by Home’s GP practice). We shall strive to ensure that the GP of any person vaccinated by us will be informed of this to prevent re-vaccination etc. |
|  | UNISON | 4 | UNISON continues to actively support and promote the flu vaccine campaign each year at a national and local level  In summer 2018 it became clear that policy-makers were giving serious consideration to setting out an expectation of 100% coverage (for staff in patient-facing jobs) and making it mandatory for staff to have the jab.  Many trade unions have long-standing policy positions against making the vaccine mandatory, so this decision would have meant that the trade unions would have had difficulty in engaging with partnership work to increase take-up of the vaccine.  Making the jab mandatory would have affected local trade union approaches to the vaccine campaigns. This is likely to have meant staff sides withdrawing participation in flu vaccine campaigns, but could also have led to active opposition and campaigns against mandating being run in organisations.  There were also strong concerns that introducing a mandatory policy could have unintended consequences amongst those staff who are usually willing to have the jab: We know that many organisations are able to persuade a very high percentage of their staff to have the jab voluntarily.  We note the NICE committee discussion NICE guideline [NG103] Published date: August 2018, on mandating the vaccine:  “Qualitative studies of mandatory flu vaccination schemes in paid health and social care employees report a negative impact on morale, leaving people feeling disempowered, lacking autonomy and resentful [Evidence review 4: Q-ES3.8, Q-ES3.9].”  There was a risk in our view that mandating the jab could lead to take-up going down rather than up.  There is a lack of clarity about what levers could be used for ‘making’ staff have the jab. Would trusts discipline staff who refused to have the jab? How would appropriate sanctions be determined? What would happen if there were wholesale refusal in particular units/sites? There is little in the way of case law on this issue but attempts to change contracts could lead to this area being tested through the courts.  There is very little evidence to suggest that mandating would do anything other than cause hostility at local level, create further administrative problems for organisations and potentially lead to time-consuming legal and ethical challenges.  We were therefore supportive of the approach taken in 2018 as an alternative to mandating the jab, but will be keen to review the impact of the changes that were made by NHS England. Especially the decision to include an instruction to employers of health and social care staff of a national expectation of 100% uptake. This led to a small number of employers acting as if the flu vaccine was mandatory.  Why collect opt-out information?  There is not a comprehensive set of information about why people turn down the vaccine. Reasons we hear include:  • Vaccine has not been effective in some years  • Concerns about allergies and adverse reactions  • Vaccine is not vegan  • Vaccine conflicts with beliefs  • Needle-phobia  Collecting better information about the reasons for opting out would help to indentify how to influence the development of the vaccine and produce materials that addressed concerns.  We support a full participation vaccination strategy, with nationally agreed opt out criteria and the advice to develop the flu vaccination strategy in conjunction with trade union [staff] representatives. We also support anonymous surveys of reasons for opting out, which could be used to inform future flu vaccination programmes.  [Recommendations 1.7.3 and 1.7.7 Flu vaccination: increasing uptake NICE guideline [NG103] Published date: August 2018]  For these reasons, we have encouraged our representatives to talk to flu leads about how those opting out could be encouraged to feed back their reasons to target support and education to overcome barriers, such as needle phobia, or misinformation about the flu vaccine's safety and effectiveness and increase take up.  For this reason we do not support declination policies as these will worsen employment and industrial relations, and may have a counterproductive impact on uptake.  In the social care sector we are concerned that there are a number of factors which will limit take up of the vaccine. There are over 20,000 individual social care employers in England and many of them are very small and local in nature. We are sceptical that many of these organisations will be able to effectively co-ordinate any form of messaging to their workers. By way of illustrating this, a recent piece of research by UNISON has shown that significant number of social care employers have failed to observe the law around producing itemised payslips for workers which was introduced in April 2019. There are many social care organisations that are hard to reach. Furthermore, local councils vary in their ability and willingness to engage with the social care providers that they commission to provide services for their local population. Furthermore, compared to the NHS, the quality of data about the social care workforce is significantly lacking which will make it difficult to gauge how many social care workers have had the vaccine. |
|  | British Lung Foundation | General | We support the development of these quality standards. People with chronic respiratory conditions are more at risk of complications due to flu and they are seven times more likely to die if they do contract flu. Only 49.8% of people received the flu vaccine in 2018/19, and uptake has barely increased over the years. In comparison, patients with diabetes, another clinical at-risk group for flu, achieved an uptake of 63.6% last year. This is much closer to the Government’s long-term ambition for uptake among clinical at-risk groups to reach 75%. The implementation of these quality standards will be an important step towards reaching this target for people with chronic respiratory conditions.  The Taskforce for Lung Health, a coalition of 30 organisations from across the lung health sector, including the British Lung Foundation, supports this aim and also recommends that 100% of health and social care workers receive the flu vaccination. |
|  | Care England | General | Lastly, Care England and other trade associations often have strong personal and working relationships with their members. Trade associations should be utilised in the dissemination of information regarding this Quality Standard. |
|  | Carers Trust | General | Carers Trust broadly welcome the Quality Statements and the explicit inclusion of carers in the eligible groups' sections, and the references to the NICE guidelines on flu vaccination: increasing uptake guidelines, which contains a section specifically focussing on carers. |
|  | Carers Trust | General | Professionals and services should be encouraged to identify unpaid carers of people who are eligible for the flu vaccine due to their medical condition or age, in particular older people who need support because of their age.  For example, people who live with many of the chronic conditions listed in the Annual Flu Letter (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/788903/Annual\_national\_flu\_programme\_2019\_to\_2020\_.pdf) are likely to have informal carers. Likewise, individuals who are aged over 65 and are frail are also likely to have a carer who may already be eligible for the flu vaccine due to their age or their caring status.  The carer is likely to be present with the individual when they receive the flu jab, so this would be a convenient time to identify the carer and suggest that they get a flu jab. The time with the medical professional administering the flu jab can also be a useful chance to ask the carer how they are, away from the person they care for, and suggest interventions to a carer e.g. booking a screening appointments, or referring to a local carer support organisation.  The Quality Standards should encourage professionals to identify carers of eligible individuals and make clear the carers’ eligibility for the flu jab (as a carer), as well as making them aware of local carer support organisations. |
|  | Carers Trust | General | The phased roll out of the flu vaccination to all children aged between 2 and 17 who are not in a clinical risk group is also a good opportunity for professionals and services to identify young carers and young adult carers, and for young carers and young adult carers to receive the flu vaccination, as this will benefit them, as well as the person they care for.  The professionals administering the vaccinations should be encouraged to ask questions to this age group to find out if they do provide care for a parent or sibling. This will enable health professionals and services to identify young carers and young adult carers, refer them for an assessment with local authority colleagues, and put in place, or signpost to, the health support they need.  If the flu vaccination happens in an educational setting, any information received about a young carer or young adult carer’s caring situation should be passed on to the school or college, as well as the health professional administering the vaccine signposting the young carer or young adult carer to their own GP or school nurse.  This step would significantly help in identifying people aged 17 and below who provide care and help put into place the support they need. |
|  | NHS England and NHS Improvement | General | Does this draft quality standard accurately reflect the key areas for quality improvement?  There is insufficient guidance and a lack of standards being set in relation to improving uptake in vulnerable groups that are underserved by the programme. It is widely accepted in primary care that some groups are less likely to respond than others to “standard” communications and also are less likely to attend “usual” locations for opportunistic immunisation. Further guidance around specific programmes to address this would be beneficial – particularly in the use of social care contacts and engagement with the relevant populations to identify how their needs can be met. It is too often the case that groups are felt to be hard to reach when in reality we are failing to understand what methods and channels would be suitable.  An expectation that commissioners will make specific provision for groups that are underserved with an acknowledgement that funding would need to be made available would go some way to address this and allow tailoring of services to meet local need.  Specific advice on young people leaving care and the obligation of social and health services to deliver joined up services for this marginalised group would be advisable.  A specific standard in relation to this issue should be considered. (YK) |
|  | NHS England and NHS Improvement | General | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Data collection arrangements for standards 1 and 4 are in place, if current provision remains unchanged, however it does not always include provision outside the NHS e.g. independent sector employers, occupational health programmes and individuals electing to obtain the vaccine outside the NHS.  Any change in provision of immunisation should only be commissioned if the data sharing agreement and quality standards are met - this should form specific advice to commissioners and providers to emphasise the obligation to ensure communication of care to all those involved in a patient’s care. (YK) |
|  | NHS England and NHS Improvement | General | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  The quality standard in my view describes current ways of working and commissioning of services for flu vaccine and as such would not require additional resource. (YK) |
|  | The Royal College of Physicians and Surgeons of Glasgow | General | The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.  The College considers that immunisation against Influenza should be offered in a timely manner annually to those at risk. It notes often those most at risk have difficulty communicating with the Health Service. The NHS needs to search out those who may most benefit from Influenza immunisation and make sure they receive it. The College notes the recent increase in cases of Measles which are resultant from a poor uptake of immunisation in childhood. |
|  | Royal College of Physicians of Edinburgh | General | In general the draft quality standard is to be welcomed.  College Fellows have stated that it is important that as much of the health information resources to be used are generated on a national basis for GPs to use and not left to individual areas to develop their own unless there are specific populations who need such an approach. This avoids unnecessary duplication of efforts, variability and excess cost. It also allows primary care clinical teams to focus more on flu vaccination engagement and delivery. |
|  | Royal Pharmaceutical Society | General | For all statements, groups of people who are underserved by flu vaccination programmes are listed. Community pharmacists and their teams are more likely to see these people than in any other healthcare setting, so consideration should be given as to how to support community pharmacies to ensure these people receive their flu vaccinations. |
|  | Royal Pharmaceutical Society | General | Overall, we welcome the fact that the role of community pharmacists in providing flu vaccination and increasing the number of eligible people who are vaccinated is recognised in this quality standard. |
|  | The Dirac Foundation | General | The question “Which flu vaccine?” should automatically fall into scope the moment different patient segments such as elderly, ethnic groups, location etc. are accepted into scope. The benefits of flu vaccination individually and to reduce propagation vary depend on the characteristics of the person being vaccinated and the strata (e.g. age group, and ideally ethnic HLA genomic group) to which the patient belongs but also on what influenza viruses are circulating that season and in which geographical locations. The patient and relevant flu type can make radical differences to the efficacy of the vaccination individually and in the ability to prevent propagation epidemiologically. Uptake enhancement must be continually targeted. Influenza vaccines vary not only by type and subtype but more subtly in their clinically important epitope variants. Without such considerations, the benefits of increasing patient uptake can be greatly weakened, and inappropriate variants of flu vaccine may be wasted on wrong segments of the population giving both a false indication of efficacy individually and epidemiologically, and needlessly using up valuable supplies. In other words, simply increasing uptake in broad strokes can be counterproductive. We need better and more fine grained clarity to professionals and stakeholders on flu vaccination type, a data bank and improved monitoring to partition uptake according to the above considerations. According to the Public Health England Commissioning Central Team Operations we know that the 2018/19 flu season has been challenging for practices because of an NHS England policy change and the introduction of a new vaccine. Suppliers are being changed. While the WHO advises on the flu strains to be used as the basis of vaccine production, there is no guarantee that these vaccine producing organizations use strains with the same molecular and hence potential immunological identity. The decision was made to work with all four remaining flu vaccine companies for the 2019/20 season, MASTA, Mylan, Sanofi and Seqirus. Even in a single supplier there are changes and flu strain options, Sanofi, for example, produces diverse flu vaccines for different strata of the community and there have been recent delays in production that could affect the practical availability of some types. |
|  | Royal College of Paediatrics and Child Health | About this quality standard | Should number of cases of flu be an outcome? |
|  | Company Chemists Association | 1. Does this draft quality standard accurately reflect the key areas for quality improvement? | Yes, however, we believe that by taking a system wide approach, there may be additional opportunities to both increase quality and uptake. Currently patients who are eligible for a vaccination may be identified through GP records and contacted by their GP surgery to invite them to receive their vaccination. In order to increase uptake, we would like to see patients provided with advice highlighting the full range of options they have to make sure they receive the vaccination at a time and place that is convenient for them. These options will include community pharmacies which are often able to deliver flu vaccinations at times when the GP surgeries are closed, i.e. in the evening and at weekends.  The notification to patients should also inform them that when they receive their vaccination in pharmacy, this will be recorded and communicated back to their General Practitioner.  We believe that taking a system wide approach to vaccination will better address population-based health needs and improve uptake. Additionally, we would like to see a system wide approach taken to identifying patients. This would need to be a co-ordinated method, to avoid where possible duplication of messages, but we recognise that areas across the country where there are no other healthcare providers can deliver an accessible and convenient flu vaccination service for the public.  With regards to identifying patients, pharmacists are more likely to have direct contact with patients who fit the eligibility criteria and can offer patients a vaccination when it’s flu season when they are dispensing medications .  A walk-in service for flu vaccinations may help to increase access and support those who fall within the vaccination criteria but are underserved by current flu vaccination programmes. This group includes:  • people who are homeless or sleep rough  • people who misuse substances  • asylum seekers  • gypsy, Traveller and Roma people  • people with learning disabilities  • young people leaving long-term care  In terms of safety, community pharmacy operates under quality standards in addition to the NICE guideline, Flu vaccination: increasing uptake (2018). These are as follows:  • Service specification developed by NHS and the Pharmaceutical Services Negotiating Committee (PSNC) as part of the Community pharmacy seasonal influenza vaccination advanced service.  • Employer specific standard operating procedures (SOPs) for delivering flu vaccination.  • Patient Group Directives (PGD) allow patients to issue specific prescription only medications (including flu vaccinations) to eligible groups without a doctor or a prescription. This sets out additional safety requirements, and it’s worth noting that the eligibility requirement for issuing flu vaccinations under the PGD is different from the NICE quality standard. The PGD does not cover children under the age of 18. |
|  | The Royal College of Physicians and Surgeons of Glasgow | 1. Does this draft quality standard accurately reflect the key areas for quality improvement? | Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?  In general, the standards have reflected key areas. However, they are relatively passive. This needs to be an active process targeting groups which may not communicate in usual ways. It should be remembered that many elderly people are not computer literate. There needs to be an active process for elderly people, homeless people occupants of long stay care or nursing homes, inmates of HM Prisons and patients of Mental Health or Learning Difficulty Services.  Other groups which may miss out are those whose first language is not English or those who cannot read or write  Many individuals were vaccinated late last year because of poor supplies of vaccine and slow primary care service. They therefore did not get full benefit of immunisation |
|  | Sheffield Teaching Hospitals NHS Foundation Trust | 1. Does this draft quality standard accurately reflect the key areas for quality improvement? | The draft quality improvement document accurately describes the process well-embedded across Sheffield but stops short of addressing the underlying reasons why vaccination rates are low. |
|  | Company Chemists Association | 2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? | There are systems and structures in place to ensure that data is collected when pharmacies provide patients with their flu vaccinations.  The current service specification notes that:  ‘The pharmacy contractor must maintain appropriate records to ensure effective ongoing service delivery. The minimum requirements for the information which should be included in a contractor’s record of provision of the service to a patient are the mandatory sections indicated within the Flu Vaccination Record Form15 which is set out in Annex E. Pharmacy contractors can use this form to maintain their record of service delivery or the information can be recorded on an alternative form or in another way, such as an electronic system.’  This means that pharmacy systems, including Sonar and Pharmaoutcomes (in England) and Chose Pharmacy (in Wales), can be used to electronically record uptake of the service. To further enhance this system, investment is needed to ensure that the record the pharmacist makes automatically connects to the patient’s GP record. This is to ensure that GPs treating the patient after the pharmacist can see if the patient has been vaccinated elsewhere. Current systems send a notification to the GP which then needs to be added to the patient record. An integrated system would mitigate the risk that the patient could be vaccinated twice and would be more efficient. |
|  | Sheffield Teaching Hospitals NHS Foundation Trust | 2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? | Yes, as above- systems are established in Sheffield |
|  | Company Chemists Association | Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services | To deliver these services through pharmacy, there is a cost incurred with regards to:  • Renewing vaccination technique every three years (in addition to anaphylaxis and British Life Saving training– all in line with the Green Book on Influenza)  There may also be a sundry cost associated with holding an appropriate number of vaccinations. Individual contractors may require pharmacists to store medicines in different areas for safety, this may incur costs if additional fridges are required. However, this is unlikely to affect Scottish contractors, as there are limits there to how many vaccinations a pharmacy can hold.  There may be opportunities for efficient ways of working through a collaborative approach to addressing population health-based needs. Community pharmacy can help to relive pressure on GPs by reducing footfall into surgeries and allowing them to focus on more complex medical cases. |
|  | The Royal College of Physicians and Surgeons of Glasgow | Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services | Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  The key at risk groups are the hardest to contact and therefore a proactive system is required. Extension of health visitor or community nursing services in this area would not only allow review of general health care but satisfactory immunisation. |
|  | Company Chemists Association | Question 4  (Local practice case studies) | In Cardiff and Vale Health Board, Collaborative Working Schemes promote discussion across the system about services that can be delivered through an integrated approach. A local surgery practice manager and a pharmacist met as part of this initiative and developed a collaborative approach to meet the GP surgery’s target of delivering vaccinations to all over 75’s. As the surgery was unable to unilaterally deliver the flu vaccinations, the pharmacist sought permission from their employer to order the required 500 vaccinations and deliver this off site, with the practice manager from the surgery present. This example of innovative working demonstrates how community pharmacies and GP surgeries can successfully work together to meet population health-based needs. |
|  | The Royal College of Physicians and Surgeons of Glasgow | Question 4  (Local practice case studies) | Question 4 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.  no |
|  | St John Ambulance | Question 4  (Local practice case studies) | “Consideration needs to be given to how best to invite these groups for flu vaccination and how best to enable access for them.”  The following list outlines the measures that St John Ambulance (SJA) Hastings Homeless Service (HHS) has taken to increase uptake of flu vaccinations amongst rough sleepers and other members of the local ‘street community’: people often referred to as ‘hard-to-reach’, ‘under-served’, or ‘marginalised’:  • For a number of years HHS has provided flu vaccinations to this client group, by means of Nurse Independent Prescribing, from stock purchased by SJA, at accessible drop-in clinics at a homeless day-centre. Availability of vaccines is advertised in the centre through posters, flyers, and opportunistically as clients present to the clinics.  • In order to broaden opportunities for vaccination, SJA flu policies and procedures were extended to enable volunteer nurses to administer flu vaccinations through Patient Specific Directions ordered by the service’s Nurse Independent Prescriber (NIP).  • The Green Book states that: “The list [of clinical risk groups] above is not exhaustive, and the medical practitioner should apply clinical judgment to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself. Influenza vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above.” Therefore, all rough sleepers are offered the vaccine by HHS, regardless of existing medical conditions, due to the extreme vulnerability associated with their circumstances.  • Having also identified that many rough sleepers known to services were not accessing the day-centre, the HHS initiated street outreach sessions, whereby the NIP accompanied outreach staff from a partner rough sleeper outreach service during winters of 2017/18 and 2018/19, offering flu vaccines on the streets from stock carried in an approved vaccine cool bag. This proved to be a successful venture, with high uptake.  • In winter 2018/19, the service was further extended by offering flu vaccines at another supportive venue for homeless and vulnerably housed people.  • Plans for 2019/20 include continuation of the above measures, with the addition of a medical vehicle to allow both better privacy and greater reach.  • In all the above scenarios, service users’ GPs are fully informed of the vaccination, including details of the vaccine and a copy of the signed consent form.  Service users who are not currently registered with a GP are also offered a vaccine. |

## Registered stakeholders who submitted comments at consultation

* Association of Respiratory Nurse Specialists
* Asthma UK
* British Lung Foundation
* British Society for Immunology
* British Thoracic Society
* Care England
* Carers Trust
* Company Chemists Association
* Department of Health and Social Care
* NHS England and NHS Improvement
* Primary Care Respiratory Society
* Public Health England
* Royal College of General Practitioners
* Royal College of Paediatrics and Child Health
* Royal College of Physicians of Edinburgh
* Royal Pharmaceutical Society
* Sanofi Pasteur
* Sheffield Teaching Hospitals NHS Foundation Trust
* St John Ambulance
* The Dirac Foundation
* The Royal College of Physicians and Surgeons of Glasgow
* UNISON

# 

1. PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees. [↑](#footnote-ref-1)